Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ADVANTAS RX
SUITE 112
2805 PEACHTREE INDUSTRIAL BLVD
DULUTH GA 30097

Carrier's Austin Representative Box
Box Number: 15

Respondent Name
INDEMNITY INSURANCE CO

MFDR Date Received
APRIL 6, 2012

MFDR Tracking Number
M4-12-2549-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At AdvantasRx, we determine the amount to bill using Texas Administrative Code 134.503 section (a) paragraph (2). AdvantasRx uses Medi-Span exclusively to determine AWP… The AWP used to calculate the Bill Amount is valid for the Date of Service in question."

Amount in Dispute: $9.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Coventry's Provider Bill Review department reviewed the above mentioned dates of service and found that the provider was not due additional money. It has been determined that Coventry will stand on our original recommendation of $708.23. The provider's formula for reimbursement is greater due to AWP rate being a higher than fee schedule. The provider has indicated the AWP for Medispan is as follows: Viagra 00069422030-22.3125. The Medispan rate for Date of Service 04/05/2011 is as follows: Viagra 00069422030-21.42."

Response Submitted by: Coventry, 5130 Eisenhower Blvd., Ste. 150, Tampa, FL 33634

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 5, 2011	VIAGRA TAB 100MG	$9.73	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute. .
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – (45) – Charges exceed your contracted/legislated fee arrangement.
   - 2 – (W1 – Workers Compensation State Fee Schedule Adjustment.
   - * – We are unable to recommend an additional allowance since this claim was paid in accordance with the state's fee schedule guidelines, First Health Bill Review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the service in dispute is April 5, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on April 6, 2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §§413.031 and 413.019 (if applicable), the division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 13, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.